# **SPHERE** Summer Program **2025**YOUTH CAMP HEALTH EXAM/RECORD FOR CAMPERS AND STAFF

Physical Exams Are Valid For 3 Years From Date of Last Examination

## Even if you are a returning participant, new forms must be filled out each year.

Address		Dat	te of Birth	Phone		
Guardian Name (if un			Telephone			
			Telephone			
TO R	 E <i>C</i> OMPLET	ED RY THE S	SPECIFIED MED	ICAL PRACT	ITIONER	
10 B	L COMI LLT			iche i mich	HIONER	
			Date of Exam / /			
			Date			
May particip	ate in all camp activit	ies				
Medical information p	pertinent to routine c	are and emergencies	5:			
			ation(s)? 🗆 YES 🗆 NC		mes of medication	
Is this individual takin	g prescription or ove	r the counter medica	ation(s)? 🗆 YES 🗆 NC	If yes, indicate na		
Is this individual takin  Does the individual ha	g prescription or ove ave allergies?	r the counter medica	etion(s)?	If yes, indicate na		
Is this individual takin	g prescription or ove ave allergies?	r the counter medica	ation(s)? 🗆 YES 🗆 NC	If yes, indicate na		
Is this individual takin  Does the individual ha  Is the individual on a s  Does the individual ha  This camper/staff is u	g prescription or ove ave allergies? special diet? ave special needs?	r the counter medica  YES	etion(s)?	If yes, indicate na		
Is this individual takin  Does the individual ha  Is the individual on a s  Does the individual ha	g prescription or ove ave allergies? special diet? ave special needs? p-to-date on all the fo	r the counter medical YES	etion(s)?	If yes, indicate na	American Academ	
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### SPHERE Summer Program 180 Bloomfield Ave Hartford CT 06105 Ph-860.236.5618 FAX-860.233.8295

#### **AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SPHERE Staff**

Connecticut State Law and Regulations 10-212(a) require a written medication order of an authorized prescriber, (physician, dentist, advanced practice registered nurse or physician's assistant) and parent/guardian written authorization, for the nurse, or in the absence of the nurse, a designated director or first aid instructor to administer medication. Medications must be in the original properly labeled container and dispensed by a physician/pharmacist.

#### **Prescriber's Authorization**

Name of Student:		Date of Birth:	
Address:			
Condition for which drug is being administered: _			
Orug Name:	Dose:		Route:
Time of Administration:	!	f PRN, frequency:	
Relevant side effects: $\square$ None expected $\square$ Spec	-		
ALLERGIES: ☐ NO ☐ YES ( <i>specify</i> ):			
Medication shall be administered from:		to	_
Month Prescriber's Name/Title:	/ Day / Year	Month / Day / Year	
Telephone: Fax:			
Address:			
Prescriber's Signature:			
			Use for Prescriber's Stamp
I hereby request that the above ordered media SPHERE with no more than a 45 day supply of multiple within one week following the last day of SPH Parent/Guardian Signature:	nedication. I unde IERE.	istered by SPHERE staff. I u erstand that this medication	
	N OF MEDICATIO	N AUTHORIZATION/APPROV	'AL
Prescriber's authorization for self administration:	☐ Yes ☐ No	Signature	Date
Parent/Guardian authorization for self administration:	☐ Yes ☐ No		
		Signature	Date

Summer Immersion Nurse approval for self administration: $\square$ Yes $\square$ No		
	Signature	Date